**IMPORTANT INSTRUCTIONS: Prior to submitting this form, all applicants must review the important disclosures and information found on www.unuminfo.com/PSEA or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-877-286-2852. DO NOT submit this form if you have not reviewed those materials.**

*Underwritten by:*
Unum Life Insurance Company of America
LTC Department
2211 Congress Street
Portland, Maine 04122

# *PACIFIC SERVICE EMPLOYEES ASSOCIATION*

## Contracted Employee (1099)
## Benefit Election Form
## Long Term Care - Policy #907754-002

| **Employee ID #** | | |
|---|---|---|
| Your Name: (Last Name, First, Middle Initial) | Social Security Number<br>__ __ __ - __ __ - __ __ __ __ | Date of Birth (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| Street Address | Gender<br>□ Male □ Female | Date of Hire (MM/DD/YYYY)<br>__ __/__ __/__ __ __ __ |
| City, State, Zip Code | Home Telephone #<br>( ) | Work Telephone #<br>( ) |
| Work Email Address: | | |
| Personal Email Address: | | |

**Is this a change to existing coverage? □ Yes □ No**
**If yes, please note that all elections made below will replace existing coverage upon underwriting approval, if applicable.**

**Plans – Check one**

| □ **Plan 1** | □ **Plan 2** |
|---|---|
| • Facility<br>• 100% Home and Community Based Care | • Facility<br>• 100% Home and Community Based Care<br>• 5% Compound Inflation |

**Facility Monthly Benefit Amount – Check one**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| □ $2,000 | □ $3,000 | □ $4,000 | □ $5,000 | □ $6,000 | □ $7,000 | □ $8,000 | □ $9,000 |

**Facility Benefit Duration – Check one.** **Duration of benefits may vary depending on where benefits are received.**

| | | |
|---|---|---|
| □ 3 Years | □ 6 Years | □ Lifetime |

- **All applicants** must complete this Benefit Election Form and the Long Term Care Insurance Application (medical questionnaire) for any selection.
- A signed Authorization to Request Medical Information (form #6720-03-CA in the kit) must accompany all medical questionnaires.

**Form is continued on reverse side.**

## Calculate Your Premium:

To calculate your premium, please refer to the rate sheet in your kit and use the calculation below, or refer to the calculator at http://unuminfo.com/PSEA

_____ **X** _____ **÷ $1,000 =** _____

Rate for plan chosen  Monthly benefit amount  Your premium

## Disclosures:

**Note: We may have the right to deny benefits or rescind insurance if any of the information provided on this enrollment form is incorrect.**

**REQUEST FOR SIGNATURE:** Please read this entire form carefully before signing below.

I certify that all statements are true to the best of my knowledge and belief. I have read and understand that, for coverage that does not require me to submit evidence of insurability, loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after my effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to my coverage.

**Employee**: Please select payment method: ☐Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR**

Billed directly (paper) by the insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

**Your premium: $**_____ (Transfer from calculation above)

_____ Employee's Signature

__ __/__ __/__ __ __ __ Date

**Contract Employee (1099): Please sign and mail all required signature forms to 14715 NE 95th Street, Suite 200, Redmond, WA 98052.**

**If you have questions about Long Term Care coverage, please call LTC Solutions Insurance Services' toll-free number 1-877-286-2852 or email info@ltc-solutions.com.**